IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER– Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

7007 0710 0002 7979 0444

April 1, 2009

REPLACES LETTER SENT EARLIER APRIL 1, 2009

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

RE: Idaho State School And Hospital, Provider #13G001

Dear Ms. Broetje:

Based on the follow-up survey completed at Idaho State School And Hospital on March 27, 2009, by our staff, we have determined that Idaho State School And Hospital is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Condition of Participation on Client Protections (42 CFR 483.420). To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Idaho State School And Hospital to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **April 20, 2009. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than April 10, 2009.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by April 14, 2009. If a request for informal dispute resolution is received after April 14, 2009 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

Susan Broetje – Administrative Director
IDAHO STATE SCHOOL AND HOSPITAL
Idaho Developmental Resource Center
1660 11TH Avenue North
Nampa, Idaho 83687-5000
PHONE 208-442-2812
Fax 208-467-0965
EMAIL broetjes@dhw.idaho.gov

April 10, 2009

Debbie Ransom, R.N. R.H.I.T.
Bureau Chief
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

RE: Idaho State School and Hospital, Provider #13G001

Dear Ms. Ransom:

Please consider this letter and the information contained within to be a credible allegation that the Idaho State School and Hospital has implemented system changes and provided training to correct the concerns that led to Conditions of Participation not being met in the recertification survey which was completed on March 27, 2009.

The facility identified all individuals who are in need of a guardian to assist them in advocating for their rights and decision-making. Service plans have been developed to outline the steps for recruiting a guardian. Additionally, wherever possible, the facility has identified people who can serve as representative until a guardian can be put in place.

The facility provided additional training to all reviewers of Client Information Logs and Behavior Reporting Forms which included detailed examples of the expectations for completion and review. All relevant staff were also reminded of the need for thorough completion of these documents. There is a three tier review system to ensure that all documentation is present and needed actions were completed; a)supervisor review; b) Clinician, psychiatric tech, and/or Q review; c) data entry review.

Also refer to the credible allegation letter which was submitted for the immediate jeopardy on 3/6/09 which is attached to the letter for the full details of the correction action taken.
In summary, the facility has implemented policy and procedural changes, provided additional training, and clarified roles and expectations for key staff. We believe these

changes, which have been outlined above, have corrected the concerns that resulted in the Condition of Participation being not met.

If you have any questions, please feel free to contact me at 442-2812 ext 700.

Sincerely,

SBroetje

Susan Broetje
Administrative Director

Attachments: March 20, 2009 Letter and corresponding attachment to Facility Standards

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	R 03/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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{W 000}	INITIAL COMMENTS The following deficiencies were cited during your follow up survey and complaint investigations. The surveyors conducting your survey were: Matt Hauser, QMRP, Team Leader Monica Williams, QMRP Sherri Case, LSW, QMRP Michael Case, LSW, QMRP Jim Troutfetter,QMRP Common abbreviations/words used in this report are: AWOL - Absent Without Leave BRF - Behavior Reporting Form CFA - Comprehensive Functional Assessment CIL - Client Information Log IDT - Interdisciplinary Team NOS - Not Otherwise Specified PCP - Person Centered Plan QMRP - Qualified Mental Retardation Professional SER - Significant Event Report SOC - Sex Offender Coordinator	{W 000}		
{W 122}	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on review of the facility's policies and procedures, investigations, behavior reporting forms, record review, and staff interviews it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect individuals. The facility failed to have a system in place that assured the	{W 122}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ABoetje ADM DIRECTOR 4/15/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 122}	Continued From page 1 safety of its individuals and the protection of their rights; the facility failed to have policies and procedures that were sufficiently specific to help staff identify behaviors and interventions that would assure individuals' safety; the facility failed to ensure that actions delineated in its policies were in accordance with the requirements of state law; and the facility failed to provide timely and relevant training to its staff. These failures resulted in a lack of effective systems to prevent the subjection of individuals to abuse and exploitation. The cumulative effect of these failures demonstrated the facility's non-compliance with federal requirements and constituted serious and immediate jeopardy to the health and safety of its individuals. The findings include: 1. Refer to W127 as it relates to the facility's failure to ensure that individuals were protected from on-going sexual abuse, psychological abuse and exploitation which placed the individuals in serious and immediate jeopardy.	{W 122}		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual's needs for guardianship were addressed for 1 of 2 individuals (Individual #10)	W 125		

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W 125	Continued From page 2 reviewed who did not have a legal guardian. Failure to obtain guardianship did not ensure an individual's rights were protected. The findings include: 1. Individual #10's 9/2/08 PCP stated she was an 18 year old female whose diagnoses included mild mental retardation, bipolar disorder type 2, and probable post traumatic stress disorder. Under the Client Rights section of her PCP, it stated "[Individual #10] is unable to meet the essential requirements for health and safety, and lacks the cognitive ability to make informed consents. [Individual #10] is in need of a legal guardian." The PCP provided no information as to what efforts had been made to obtain a guardian for Individual #10. Individual #10's PCP included the following restrictive interventions: - The use of Naltrexone (an antagonist drug) 100 mg daily for treatment of self injurious behaviors defined as inserting items such as staples into her skin. - The use of Prozac (an antidepressant drug) 20 mg daily for treatment of depressive symptoms of bipolar disorder defined as suicide threats and self injurious behaviors. - The use of Lithium (a central nervous system drug) 1275 mg daily for the treatment of hypomanic symptoms of bipolar disorder defined as assaults to others. - The use of Lunesta (a sedative-hypnotic drug) 2 mg daily for the treatment of sleep disturbance. - Room searches to remove items that may be used for self injurious behaviors. - The use of physical restraint up to prone to prevent injury to self or others.	W 125		

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W 125	Continued From page 3 During an interview on 3/25/09 at 11:15 a.m., Individual #10 stated she believed her parents were her legal guardians. Individual #10 stated she was not old enough to be her own guardian and did not know that she would ever be old enough. During an interview on 3/25/09 from 2:52 - 3:40 p.m., the QMRP stated Individual #10 was her own guardian but her parents signed off on restrictive programming. The QMRP stated he was unaware of any efforts being made to obtain a guardian for Individual #10. The facility failed to ensure a guardian was obtained for Individual #10.	W 125		
{W 127}	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure sufficient systems were developed, implemented, and monitored to ensure individuals were not subjected to on-going sexual assaults, psychological abuse, and exploitation from other individuals. This failure directly impacted 7 of 19 individuals (Individuals #1, #2, #11, #12, #13, #14, and #15) whose PCPs and/or CFAs were reviewed and had the potential to impact 79 of 79 individuals residing at the facility. The failure to protect individuals from on-going sexual abuse, psychological abuse and exploitation placed the	{W 127}		

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{W 127}	Continued From page 4 individuals in serious and immediate jeopardy. The findings include: 1. The facility's Aspen building was observed on 3/3/09 at 3:45 p.m. The building was divided into 2 separate living areas (Aspen group 1 and Aspen group 2) which were connected by 2 separate hallways. Double doors, located in the hallways were observed to be open. Ten individuals lived in each group. The needs of the 20 total individuals housed within the Aspen building were reviewed and included the following: Aspen Group 1: - Individual #1's PCP, dated 1/8/09, documented a 19 year old male diagnosed with mild mental retardation, schizoaffective disorder, bipolar type 2, and post traumatic stress disorder. His CFA documented he was interested in expressing sexuality and that he would not ask for further information on social sexual issues. - Individual #12's PCP, dated 2/3/09, documented a 20 year old male diagnosed with moderate mental retardation, impulse control disorder NOS, and sexual misconduct. Under the section titled Challenging Behavior/Mental Health, it stated he "invades others space in an attempt to intimidate, to get what he wants or to stop something that he finds uncomfortable, and for sexual grooming. [Individual #12] lacks many standard social skills such as the ability to state when he was beginning to feel awkward or threatened, and uses behavioral displays of aggression to make these statements (choke holds, etc.)...he has a history of sexually acting out and will use invasion of space and grooming techniques (i.e., getting close and whispering to peers (secretive	{W 127}		

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{W 127}	Continued From page 5 behavior), or telling peers, "you're my best friend," or "you can pick one of my movies to watch," or would offer edibles such as candy and gum to peers he was grooming) for the purpose of sexual misconduct." His CFA, dated 2/3/09, stated he was able to recognize physical abuse. It stated he might be able to say no, however, he would be easily taken advantage of and might not recognize when he was being abused. It stated he was able to alert staff to situations of potential harm but there were some things that he did not recognize as being wrong. - Individual #13's PCP, dated 5/1/08, documented a 31 year old male diagnosed with mild mental retardation, intermittent explosive disorder, dysthymia, and impulse control disorder. His PCP documented a history of violence including throwing knifes around the house, hitting his step father and trying to light his living room curtains on fire. His CFA, dated 5/1/08, documented he did not maintain appropriate social distance, did not maintain appropriate social boundaries, was interested in expressing sexuality, and that he would not ask for information on social sexual issues. The CFA stated he did not always understand that something was wrong, and even if he knew it was wrong he would do it if he thought he could get away with it. - Individual #16's CFA, dated 2/5/09, documented a 37 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, post traumatic stress disorder, dysthymia, and paraphilia. He was on enhanced supervision due to self injurious behavior. - Individual #17's CFA, dated 10/16/08, documented a 19 year old male diagnosed with	{W 127}		

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{W 127}	Continued From page 6 mild mental retardation, intermittent explosive disorder, bipolar disorder type 2, hypomania, and post traumatic stress disorder. Individual #17 reported he had been abused as a child. - Individual #18's Psychosexual Risk Assessment, dated 8/11/08, documented a 61 year old male diagnosed with mild mental retardation, major depression, and paraphilia. The assessment stated he had engaged in frottage (rubbing against the body of another person to attain sexual gratification) with an adult female resident from a shelter home, touched the breast of a 16 year old family member, and forced sexual activity upon his ex-wife. He had been sexually abused by a brother. The assessment stated Individual #18 should be monitored for triggers (staring at women's breast and hugging women) for sexually inappropriate behavior, and should not have unsupervised contact with any minors or vulnerable adults. - Individual #19's PCP, dated 6/28/08, documented a 35 year old male diagnosed with mild mental retardation, and history of impulse control disorder and inappropriate sexual activity including paraphilia. He had a history of neglect, physical abuse, and medical neglect. He was sexually abused by his cousins, and lived in 11 foster homes between the ages of 8 and 14. He had a history of displaying sexual behaviors (including a conviction for rape and inappropriate contact with children), fire setting, and inappropriate talk with young children. He was described as a high risk to re-offend if not maintained under close supervision. His sexual history data documented he had over 100 victims. He was a registered sexual offender.	{W 127}		

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{W 127}	Continued From page 7 - Individual #20's Psychosexual Risk Assessment, dated 1/10/08, documented a 39 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, major depression, rage outbursts, and a history of psychosis with possible schizophrenia. He spent 7 years in prison for battery with intent to commit a serious felony (rape). The assessment stated he should have supervised contact with minors and any vulnerable adults, and should have no access to items that could be used to groom a child. He was a registered sexual offender. - Individual #21's PCP, dated 9/18/08, documented a 62 year old male diagnosed with mild mental retardation and pedophilia with a history of maladaptive behaviors. He has a history of exposing himself to small children, offering them candy to have them expose themselves to him, and peeking into the windows of neighbors at night. He had been arrested and charged with lewd behavior with a minor child. He had been found in suspicious situations involving small boys and girls on numerous occasions. - Individual #22's PCP, dated 9/4/08, documented a 19 year old male diagnosed with mild mental retardation, bipolar hypomania, attention deficit hyperactive disorder, and oppositional defiant disorder. He allegedly sexually abused his sister. Aspen Group 2 - Individual #2's PCP, dated 6/12/08, documented a 36 year old male diagnosed with mild mental retardation, depressive disorder NOS, post traumatic stress disorder, delusional disorder, and sexual deviant disorder. He had a history of attempted sexual activity with his brothers,	{W 127}		

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{W 127}	Continued From page 8 sisters, schoolmates, and animals. It was also reported that he had inappropriate sexual interactions with a non-verbal, non-ambulatory, severely developmentally disabled peer. His CFA, dated 6/12/08, stated "Due to [Individual #2's] level of functioning he does not always understand that things are wrong and even if he does know they are wrong he will do something if he feels he can get away with it." - Individual #11's PCP, dated 5/15/08, documented a 26 year old male diagnosed with mild mental retardation, impulse control disorder NOS, obsessive compulsive disorder, attention deficit hyperactive disorder, fetal alcohol syndrome, and possible anti-social personality disorder. Under the section titled Emotional and Social Development, it stated "[Individual #11] is very impulsive and impatient and has a difficult time in delaying gratification. [Individual #11] lacks personal boundaries and will invade the personal space of others. [Individual #11] lacks appropriate telephone skills, and will ask for the telephone numbers of women he does not know so he can telephone them." Under the section titled Challenging Behavior/Mental Health, it stated "[Individual #11] continues to have extreme difficulties with age appropriate opposite sex relationships. Many of his telephone conversations include "phone sex," harassment and threats." His CFA, dated 5/15/08, stated he often engaged in inappropriate sexual conversations with females. It stated he would do things that he knew was wrong if he thought he could get away with it. He was a registered sexual offender. - Individual # 14's PCP, dated 10/1/08, documented a 21 year old male diagnosed with	{W 127}		

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{W 127}	Continued From page 9 moderate mental retardation, bipolar type 1, depressed with psychosis, psychosis NOS, impulse control disorder NOS, post traumatic stress disorder, borderline personality traits, and gender confusion. He had a history of colonic polyps secondary to manipulation with his finger and other foreign objects in the rectum and required 1:1 staff supervision. His CFA, dated 10/1/08, documented he could recognize physical abuse but would not always recognize psychological/emotional abuse. - Individual #15's PCP, dated 9/25/08, documented a 22 year old male diagnosed with mild mental retardation, oppositional defiant disorder by history, and intermittent explosive disorder. His CFA, dated 9/26/08, stated he had a high risk for grooming and stalking and he maintained detailed notes on pictures he collected of potential victims, and he would rate the victims according to his own sexual response to them. His polygraph, dated 2/17/09, stated "Due to his increased feelings of sexuality and his need for comfort it is the opinion of this examiner that other male individuals especially those impacted with MMR or developmental disabilities may be more at risk. Due to his failed polygraph regarding fantasies of rape and violence and current manipulative behaviors I would classify [Individual #15] as a moderate risk. Due to feelings and statements I would place special concerns for [staff's name] and staff member [staff's name]." - Individual #23's CFA, dated 11/25/08, documented a 31 year old male diagnosed with mild mental retardation, major depression with psychosis, obsessive compulsive disorder, and attention deficit hyperactivity disorder. There was	{W 127}		

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{W 127}	Continued From page 10 no documentation of sexual issues. - Individual #24's Psychosexual Risk Assessment, dated 8/11/08, documented a 37 year old male diagnosed with mild mental retardation, cerebral palsy, and frequent suicidal ideation. The assessment documented over 60 sexual assault victims. The assessment stated he should be supervised carefully around any female staff or community member, should avoid all contact with adolescent females, and any contact with minors should be strictly supervised. Legal charges should be pressed if he committed any crimes of a sexual nature. - Individual #25's PCP, dated 8/6/08, documented a 41 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, and pedophilia. He had a history of sexual offenses with his youngest victim being 18 months old. He was exclusively attracted to very young children and assessment findings suggested he was extremely sexually aroused to forceful types of sexual behavior with female populations. It was felt he was too dangerous for jail because he would physically assault fellow prisoners as well as jail personnel. - Individual #26 is identified by the facility's client roster as a male with mild mental retardation. - Individual #27's Psychosexual Risk Assessment, dated 8/21/08, documented a 31 year old male diagnosed with mild mental retardation, and by history schizophrenia, impulse control disorder, post traumatic stress disorder, borderline personality disorder, and paraphilia. The assessment stated he had a diaper fetish and that he should not have unsupervised contact	{W 127}		

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{W 127}	Continued From page 11 with any minors or vulnerable adults. - Individual #28's CFA, dated 4/17/08, documented a 20 year old male diagnosed with mild mental retardation, attention deficit hyperactivity disorder, post traumatic stress disorder, and schizoaffective disorder. The assessment stated he did not always understand why something was wrong so he would do it anyway. The assessment stated he engaged in inappropriate sexual contact, but the CFA did not include specific information. When asked, the SOC stated during an interview on 3/5/09 from 1:16 - 2:48 p.m., Individual #1 and Individual #2 were at risk for sexual exploitation, Individual #13 would be a willing participant, Individual #14 would be a willing participant if not under one to one staff supervision, and he was not sure about Individual #15 as he was fairly new to the facility. In summary, of the 20 individuals living in the Aspen building, no less than 19 had a history of sexual abuse victimization, no less than 18 had a history of perpetrating sexual offenses, and 3 of those individuals (Individuals #11, #19, and #20) were registered sexual offenders. The facility's system to prevent abuse, neglect and mistreatment was reviewed. The system was not sufficient to ensure individuals at the facility were protected from sexual abuse, psychological abuse, and exploitation from other individuals as follows: The Administrator was interviewed on 3/6/09 from 9:18 - 10:34 a.m. When asked about investigations of abuse, the Administrator stated	{W 127}		

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{W 127}	Continued From page 12 there were two types of investigations. The first type was formal investigations which were typically related to staff to client abuse or neglect, and were completed by an investigation team. It was the responsibility of the QMRP and IDT to investigate incidents of client to client abuse. Those investigations were completed on a Team Review and Action Plan for Significant Events form. When asked to explain the Client Information Log policy and Client Behavior and Incident Reporting policy, the Administrator stated that these policies replaced the Client Significant Event and Client Minor Event policies. When asked to explain the process with the new policies, she stated that staff document the event time, type, level, and complete the narrative section (the antecedent, behavior, and consequences) and include, as applicable, the victim of the behavior. She further explained that if there was a victim, a BRF would be generated for both the victim and the perpetrator. The Administrator further stated that the new system had only been in place for about a month and there could be some errors. When asked about tracking and trending of the data, the Administrator stated Records Specialist personnel review for missing information, as well as for correlation between CILs and BRFs. The Administrator also stated that a follow up training on the Client Information Log policy and Client Behavior and Incident Reporting policy was scheduled for 3/16/09, to address any issues with the newer policies and procedures. When asked what was supposed to happen if patterns of psychological abuse were identified for an individual, the Administrator stated that the	{W 127}		

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{W 127}	Continued From page 13 individual's team was expected to conduct some level of investigation to resolve the issues. The facility's Client Behavior and Incident Reporting policy, effective 1/12/09, addressed individual to individual incidents. The policy was not sufficiently developed, implemented and monitored to ensure all incidents of sexual assault, exploitation and psychological abuse were immediately reported, investigated, and that appropriate corrective action was taken to ensure individuals were not subjected to ongoing abuse and mistreatment as follows: The facility's Client Behavior and Incident Reporting policy, effective 1/12/09, included procedures for completing BRFs for events including, but not limited to, client to client physical assault, psychological assault, sexual assault, sexual misconduct, and exploitation. The policy stated staff were to complete a BRF anytime they witnessed or received a report of an incident that met one of the definitions in the policy. Once staff completed a BRF, they were to make notifications as indicated on the BRF. When asked about required notifications during an interview on 3/6/09 from 9:18 - 10:34 a.m., the Administrator stated the form dictated and included spaces for events that required Administration notification. She stated all client to client assaults, including those without injury, were to be reported to the Administrator. Events with injuries were also to be reported to nursing and the QMRP. The Administrator stated if an individual was repeatedly victimized without injury, and showed signs of distress, staff could report it as psychological abuse. When asked if Administrator notification was documented, she	{W 127}		

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{W 127}	Continued From page 14 stated only on the BRFs. The facility's Client Behavior and Incident Reporting policy further stated once staff completed the BRF it was routed to the Clinician or Psych Technician. The Clinician or Psych Technician was to review the BRF no later than 3 working days after completion, ensure thorough and accurate completion of the form and modify it if needed, and provide training on form completion as needed. A Psych Technician assigned to the Aspen unit was interviewed on 3/5/09 from 1:50 - 2:15 p.m. and from 4:36 - 4:46 p.m. When asked, he stated he reviewed BRFs for completion, reported significant events (as defined by policy) to the QMRP and Clinician, and then forwarded the BRFs to data entry. When asked if he reviewed Administrator notification on client to client assaults with no injury, he stated that was a "gray area." When asked, a Psych Technician assigned to the Evergreen unit stated during an interview on 3/6/09 from 9:00 - 9:15 a.m., the policy allowed him three days to review BRFs and the QMRP had a week to review them prior to sending them to data entry. When asked to clarify the BRF procedure, the Administrator stated during an interview on 3/6/09 from 9:18 - 10:34 a.m., a BRF was generated for all three shifts during a 24 hour period. The night shift pulled the previous day's BRFs, which were then reviewed by the Clinician or Psych Technician. The Administrator stated the Clinician or Psych Technician reviewed the form for completion and followed up with any missing or incomplete information, missing notifications, training issues, etc. Once the Clinician or Psych	{W 127}		

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{W 127}	Continued From page 15 Technician was finished with the form, they forwarded the BRFs to Records Specialist who entered it into a database. The Administrator stated that the QMRPs reviewed the database at least monthly. The client to client victim/perpetrator information was sent to the QMRPs and Clinicians on a weekly basis. The Administrator stated the Clinician or Psych Technician was to make a copy of any BRF with concerns or unusual events for the QMRP. If no BRF form was generated for an individual on a given day, it was assumed no behavioral incidents took place. The Administrator stated it was a similar process for Client Information Logs with the exception of the review process. She stated CILs should be reviewed by the QMRP each work day. However, per policy, CILs were reviewed by the QMRP at least weekly. The CILs were then sent to the Records Specialist. The Administrator stated any BRF or CIL documenting a significant event as defined by policy, should generate a Team Review and Action Plan for Significant Events. Once the Team Review and Action Plan for Significant Events form was completed, it was sent to the Performance Improvement Department for review. The facility's procedure allowed the BRF to remain un-reviewed for up to three working days without events deemed significant being reported to the QMRP. Additionally, incidents not appropriately reported to the Administrator could be undetected for a period of three or more working days. The policy was not sufficiently developed to ensure all incidents of abuse were	{W 127}		

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{W 127}	Continued From page 16 immediately reported to the Administrator. The facility's Client Behavior and Incident Reporting policy stated if the Clinician or Psych Technician determined the event was not significant per policy, then the form was collected by the Records Specialist for entry into a database. If it was determined the event was significant, the Clinician or Psych Technician was to provide a copy of the BRF to the QMRP immediately after review. The QMRP was to then complete an investigation of the incident using the facility's Team Review and Action Plan for Significant Events form. However, the policy did not include procedures to ensure the results of all investigations were reported to the Administrator within 5 working days. The QMRP (for Aspen Group 2) was interviewed on 3/5/09 from 4:25 - 4:35 p.m. When asked about her role in the CIL and BRF system, she stated she made necessary corrections and retrained staff related to those corrections. When asked about the Team Review and Action Plan for Significant Events form, she stated it had not been necessary to use one since the new system began on 1/12/09. When asked if she had received any significant BRFs, she stated no. When asked about the QMRP's responsibility to investigate client to client abuse, she stated it was not the QMRP's responsibility. She stated if a client to client abuse investigation was required, the information was sent to the Lead Investigator. The facility failed to ensure staff were sufficiently trained and that the policy was monitored to ensure consistent implementation of investigation procedures and protections for all allegations of client to client abuse.	{W 127}		

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{W 127}	Continued From page 17 The Client Behavior and Incident Reporting policy and forms defined incidents that included, but were not limited to, the following: - Exploitation from/of another client was defined as "a behavior or practice that makes use of a client's funds, property, or other resources for profit or advantage." The policy stated all incidents of exploitation were to be reported to the Administrator. - Psychological abuse from another, defined as "harassment or threats of harm from/to an individual." Examples included threats to hurt or kill a victim or victim's loved ones, threats to destroy the property of a victim or of a victim's loved ones, intimidation of another through destruction of property or violent gestures, harassment by ridiculing and mocking, or racial slurs, or extreme use of profanity or screaming/yelling. The policy stated the Administrator was to be notified of client to client psychological assault. The Client Behavior and Incident Reporting policy also defined significant events which included all levels of Sexual Assault. Sexual Assault was defined as "Unwanted sexual behavior between people who reside" at the facility. Sexual Assault was broken into three levels. Level 1 was defined as touching of another client on the breast, buttocks, or genital area with a sexual intent or self-exposure to another client with a sexual intent. Level 2 was defined as skin-to-skin contact of genitals, buttocks, and/or breasts of another client with a sexual intent. Level 3 was defined as oral, anal, or genital intercourse with another client or sexual penetration with a foreign	{W 127}		

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{W 127}	Continued From page 18 object to another client. The Administrator was to be notified of all incidents of Sexual Assault. The policy further stated Level 3 Sexual Assault was to be reported to Adult and Child Protection and Law Enforcement, but did not include those reporting requirements for Level 1 and Level 2. The policy was not sufficiently developed to ensure all potential sexual assaults (as defined in Levels 1, 2, and 3 of the policy) were reported to all other officials in accordance with state law. The Client Behavior and Incident Reporting policy also included Level 3 Sexual Misconduct as a significant event. Sexual Misconduct was defined as "Consensual (both parties are willing participants) sexual behavior between unmarried people who reside" at the facility. The policy stated "Any event will be deemed unwanted if either party communicates that he/she was an unwilling partner, or if one of the participants does not have the cognitive capacity for consent. When in doubt, report as assault (vs. misconduct) and the team will make the determination." Sexual Misconduct was broken into three levels. Level 1 was defined as touching of another client on the breast, buttocks, or genital area with a sexual intent or self-exposure to another client with a sexual intent. Level 2 was defined as skin-to-skin contact of genitals, buttocks, and/or breasts of another client with a sexual intent. Level 3 was defined as oral, anal, or genital intercourse with another client or sexual penetration with a foreign object to another client. The Administrator was to be notified of incidents of Sexual Misconduct Level 3. However, incidents of Sexual Misconduct Level 1 and Level 2 did not require notification to the Administrator.	{W 127}		

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{W 127}	Continued From page 19 Additionally, incidents of Sexual Misconduct Level 1 and Level 2 were not deemed significant per the policy and did not require reporting to the QMRP, even after review by the Clinician or Psych Technician. Further, the policy did not require reporting to Adult and Child Protection and Law Enforcement for any of the incidents defined as Sexual Misconduct (Levels 1, 2 or 3). The Administrator was interviewed on 3/6/09 from 9:18 - 10:34 a.m. When asked about Sexual Misconduct and Sexual Assault and how an individual's capacity for consent was ascertained, the Administrator stated that if individuals engaged in Level 1 or Level 2 misconduct and were of similar functioning levels, and both parties appeared to be willing participants and neither appeared upset or distressed, consent would be assumed and it would be Sexual Misconduct, not Sexual Assault. She added that if individuals were at different functioning levels, the incident would be considered assault for the lower functioning individual. When asked if individuals with legal guardians could consent to Sexual Misconduct without their guardians' consent, the Administrator stated they could consent based on their willingness and lack of apparent distress. However, information regarding assessments and evaluations of the individuals' abilities to consent was not included in the facility's policy. The facility's policy was not sufficiently developed to ensure individuals had sufficient understanding or capacity to make or communicate or implement informed decisions regarding sexual activity, consistent with state law. Without such information, the facility would not be able to differentiate between Sexual Misconduct (defined as consensual per policy) and Sexual Assault	{W 127}		

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{W 127}	Continued From page 20 (defined as unwanted sexual behavior per policy). Therefore, the facility could not ensure all inappropriate sexual behavior between individuals was immediately reported to the Administrator and other officials in accordance with state law. Without appropriate notifications, the facility could not ensure individuals were immediately protected, all allegations were thoroughly investigated, and timely appropriate corrective action was taken. Additionally, the Client Behavior and Incident Reporting policy did not include information regarding special provisions for individuals with known prior sexual offenses, such as reporting incidents of inappropriate sexual behavior to individuals' Probation Officers or the facility's SOC. When asked, a Psych Technician assigned to the Aspen Unit stated during an interview on 3/5/09 from 1:50 - 2:15 p.m., the BRF did not contain directions as to when to notify the SOC or Probation Officer. When asked, he stated the facility had not provided him with training on the sex offender program. When asked, a Clinician assigned to the Aspen Unit stated on 3/6/09 at 10:25 - 10:50 a.m., the facility had not provided her with training on the sex offender program and she "would love some (training)." Without adequate policy, procedures and adequate staff training, it would not be possible to ensure all allegations of inappropriate sexual conduct were identified and reported in accordance with state law and to others on the individuals' IDTs. The cumulative effect of the insufficient	{W 127}		

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{W 127}	Continued From page 21 development, implementation and monitoring of the policies and procedures, coupled with inadequate staff training allowed for individuals to be subjected to ongoing sexual assaults, psychological abuse and exploitation as follows: a. A 2/5/09 investigation report included information on two separate incidents of sexual activity on the Aspen Unit. The first incident, included in the investigation for historical purposes, was documented on a SER, dated 11/9/08. The SER stated Individual #1 reported to staff he and Individual #13 had sex in his (Individual #1's) bedroom in July, August and September. Individual #1 reported he would distract staff and Individual #13 would sneak into Individual #1's bedroom. An investigation into the incident was conducted and included the following interviews with Individual #1 and Individual #13. "[Individual #1] stated that he and [Individual #13] had sexual activity in [Individual #1's] room on many occasions. [Individual #1] would discuss with [Individual #13] about rendezvous times. It would be decided that when there was only one staff present is when they would get together. [Individual #1] stated he would wait for a staff to be alone and then go ask them for help in the kitchen or say he had a complaint about someone and then draw them into the kitchen or the TV room to talk. [Individual #1] would then leave his door open and draw the staff person away and [Individual #13] would go into [Individual #1's] room and wait for his return. [Individual #1] would come back and shut the door so he and [Individual #13] would be alone. Staff would think that [Individual #13] was in his own room and [Individual #1] was in his own room. [Individual #1] said that they had oral sex, anal sex and they	{W 127}		

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{W 127}	Continued From page 22 would masturbate each other. He also stated that the sexual activity occurred during July, August and September may be 2-3 times per week. It stopped near the end of September because [Individual #1] was getting tired of the way [Individual #13] would treat him. [Individual #1] also stated that [Individual #16] had seen them on at least one occasion and told [Individual #1] that he was nasty. This particular occasion occurred on night shift in the bushes out back. [Individual #1] said he went outside through one door and [Individual #13] went outside through another door and they met. [Individual #16] was watching through the window and spoke to [Individual #1] as he entered back into Aspen." "[Individual #13] stated that he and [Individual #1] did have sexual activity together. He said that [Individual #1] would leave his door open and then go talk to the lone staff person and have them go to the kitchen with him to help him in there. [Individual #1] would then come back to his room and shut the door. [Individual #13] stated that he would perform anal sex and oral sex on [Individual #1] and [Individual #1] would perform oral sex on him. [Individual #13] thought it was weird that [Individual #1] only got an erection on one occasion. [Individual #13] said they were involved sexual [sic] July, August and September. He also thought they had only had sex maybe 4 or 5 times but it could have been more." During an interview on 3/4/09 from 1:15 - 2:45 p.m., the SOC stated Individual #1 was at risk for sexual exploitation and Individual #13 would be a willing participant. The 11/9/08 SER plan of correction included	{W 127}		

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{W 127}	Continued From page 23 fifteen minute visual checks to see where everyone was. The second incident included in the 2/5/09 investigation documented that on 1/25/09, Individual #12 reported to staff that Individual #11 [a registered sexual offender] had been showing Individual #12 his penis in the television room when staff was not in the television room and that Individual #11 had been knocking on his window to show him his penis. The Administrator, Individual #12's legal guardian, Law Enforcement, and Adult Protection were not immediately notified. Further, the QMRP was not made aware of the allegation. When asked, the QMRP stated during an interview on 3/5/09 from 2:50 - 4:15 p.m., she had not seen the BRF before. The Administrator was interviewed on 3/6/09 from 9:18 - 10:34 a.m. When asked about the 1/25/09 BRF incident between Individual #11 and Individual #12, the Administrator stated the QMRP should have seen the BRF and investigated the incident. When informed that the QMRP had not seen the BRF, she stated it was an oversight by the Psych Technician, and was an instance of staff not following policy and procedure. The Administrator stated retraining on the policy and procedure was scheduled for 3/16/09. However, the BRF documented the incident was Sexual Misconduct Level 2 for Individual #11 and Sexual Assault for Individual #12. Therefore, in accordance with the facility's policy, the allegation was not required to be immediately reported to the Law Enforcement and Adult Protection. When asked, the SOC stated during an interview	{W 127}		

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{W 127}	Continued From page 24 on 3/4/09 from 1:15 - 2:45 p.m., he was informed of the 1/25/09 incident via an e-mail (date unknown) and immediately requested polygraphs be conducted on Individual #11 and Individual #12. No other evidence of action taken prior to 2/3/09 was included in the individuals' records. On 2/3/09, a polygraph was conducted on Individual #11 and Individual #12. The preliminary results of the polygraphs, as written by the SOC, indicated since 11/08 Individual #11 had engaged in multiple incidents of sexually inappropriate behavior with multiple peers, including repeatedly subjecting Individual #12 to exploitation as well as sexual and psychological abuse as follows: During the pre-polygraph interview Individual #12 stated the following: - Individual #11 showed Individual #12 his penis on about 8 occasions in the Aspen 2 TV room and outside by the flowerbed located between the day hall patio and the kitchen patio. - Individual #11 made Individual #12 masturbate Individual #11 on 2 occasions, once in the Aspen 2 TV room and the other time outside by the flowerbed area. - Individual #11 made Individual #12 perform oral sex on Individual #11 on one occasion outside by the flowerbed area. - Individual #11 asked Individual #12 to allow Individual #11 to have anal sex with Individual #12 on at least 6 occasions. Individual #12 refused. - Individual #11 made Individual #12 buy him pop and candy and that he was afraid of Individual #11. The preliminary report stated Individual #12	{W 127}		

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{W 127}	Continued From page 25 passed all his polygraph questions with "a high degree of honesty." The preliminary results of Individual #11's polygraph, dated 2/3/09, stated he had engaged in sexually inappropriate behavior with Individuals #1 (exposing his penis), #33 (phone sex), #40 (phone sex and fondling her breasts) and #12 (exposing his penis, oral sex, masturbation). Individual #11 stated he was having loving sexual fantasies about the female staff he worked with, and was making Individual #12 buy him candy and pop. The preliminary report further stated "The discussion after the polygraph centered on [Individual #11's] degree of deception used in the failure of loving sexual fantasies about staff indicates that his fantasies are probably about violence and control of the victim. With his degree of planning and waiting for chaos to start it is believed that he would follow through with his fantasies. [Individual #11] stated in the interview that he is willing to wait for chaos to start on Aspen because he knows that the staff become [sic] busy dealing with problems so he can fulfill his sexual plans. We believe that the female staff that he has mentioned, and possibly others could be in danger." The finalized polygraph examination report, dated 2/7/09, showed the following results from the 2/3/09 polygraph: "After the initial interview and admissions obtained, the test was administered to determine if [Individual #11] was being truthful when he said that he has not talked with [Individual #35] about sex since they broke up, other than those he has	{W 127}		

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{W 127}	Continued From page 26 disclosed he has not been grooming others for sex, other than [Individual #40] and [Individual #33] that he has not talked sexually to other females in the last 60 days, and that he has not been fantasizing about using force or violence... [Individual #11] admitted showing his penis to another client, [Individual #12], three (3) or four (4) times with the last time being one (1) month ago. He stated it has occurred mostly outside but also inside the TV room. He stated that he not only has exposed his penis but had [Individual #12] masturbate him several times. He further stated that [Individual #12] had oral sex with him 2-3 additional times while outside usually on swing shift when something is in turmoil. He stated that he has initiated the turmoil on occasion to give them the opportunity to be able to leave. [Individual #11] stated that he solicited [Individual #12] for anal sex several times but [Individual #12] stated no. He stated due to his lack availability for sexual contact with women he was looking for comfort. He stated that he does know that [Individual #12] is afraid of him and has used this to his advantage. [Individual #11] stated he also exposed himself to another client, [Individual #1]. He stated this occurred two days ago but only one time. He stated there has been no masturbation or any other sexual activity at this time with [Individual #1]. [Individual #11] admits to talking on the phone about sex with both [Individual #40 and Individual #33] from [another unit] approximately one week ago. [Individual #11] stated that he had sexual activity with [Individual #40] last week when he fondled her breasts on top of her clothing. He stated that he fantasizes about [Individual #35] and has asked her for sex in the past...[Individual #11] stated that he masturbates approximately one time daily fantasizing about [Individual #35], and	{W 127}		

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{W 127}	Continued From page 27 staff member [a female staff's name] citing that she is "hot". He denies any fantasies of other staff members. After further interviewing and questioning of [Individual #11] he also admitted to having sexual fantasies about the following staff members: [five female staffs' names]." During the polygraph examination, Individual #11 was asked "Have you had any fantasies of using force or violence?" His response was "No." His response was found to be "indicative of deception." The polygraph examination stated the following cautions in bold lettering: "CAUTION: It is the opinion of this examiner that [Individual #11] poses an extreme threat to the safety of others. He, by his own admission, has turned to other males for comfort through sexual activity and his inability to substantially interact with women. His fantasies toward [a female staff person], and other female staff members, put them at substantial physical risk. (Especially [the female staff person]). [Individual #11] stated that he watches for what he perceives would be opportunities to take advantage of a potential situation and views [the female staff person] as being particularly vulnerable. He stated that he fantasizes and masturbate about her wanting to have sex with him voluntarily but given the right situation would not turn down other options such as force or violence." When asked, the QMRP stated during an interview on 3/5/09 from 2:50 - 4:15 p.m., both the SOC and herself were present when the polygraphs were conducted on 2/3/09. The SOC, who was present during the interview with the QMRP, stated he sent the polygraph results to	{W 127}		

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{W 127}	Continued From page 28 the treatment team including the QMRP, Clinician, and the Social Worker. Two days after the polygraphs were conducted, an investigation into the allegation was initiated (on 2/5/09) for potential staff neglect. Additionally on 2/5/09, Individual #12 was moved to the other end of the building (Aspen Group 1), and the Administrator, Law Enforcement and Adult Protection were notified. However, Individual #12's guardian was not notified until 2/9/09 and the investigation was not completed until 2/18/09. The 2/5/09 investigation stated "During a polygraph examination given on 2/3/09 to [Individual #12], [Individual #12] alleged that [Individual #11] had shown his penis to [Individual #12] on eight occasions, made [Individual #12] masturbate [Individual #11] on two occasions, [Individual #12] was made to perform oral sex on [Individual #11] on one occasion and [Individual #11] makes [Individual #12] buy him pop and candy. [Individual #12] stated that he is afraid of [Individual #11] and that [Individual #11] has asked [Individual #12] to perform anal sex on him on at least six occasions in which [Individual #12] has refused. During a separate polygraph given to [Individual #11] on 2/3/09, [Individual #11] confirmed the statements made by [Individual #12] and stated that he had also had phone sex with [Individual #40 and Individual #33] and that he had fondled [Individual #40's] breasts." The investigation included the following interviews with Individuals #1, #11, #12, #33 and #40. - Individual #40 stated she and Individual #11 discussed sexual things over the phone and he sometimes talked about having sex and asked	{W 127}		

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{W 127}	Continued From page 29 her to sneak off with him. - Individual #33 stated she had discussed sexual things with Individual #11 over the phone. - Individual #1 stated he and Individual #13 had had sex in the past but they no longer did that and Individual #11 had "tried to kiss him once and it kind of freaked him out." "[Individual #1] was asked if [Individual #11] had tried to do any other sexual activities with him. [Individual #1] stated that [Individual #11] had not and he did not want to talk about it anymore." - "[Individual #12] was asked if he feels threatened by [Individual #11]. [Individual #12] stated that he thinks [Individual #11] would rape him. [Individual #12] stated that he feels threatened by [Individual #11] because [Individual #11] would tell [Individual #12's] mom that [Individual #12] did it. [Individual #12] was asked what he thought [Individual #11] would do if he did not cooperate. [Individual #12] stated that [Individual #11] would hurt him." - "[Individual #11] was asked if he felt threatened by any of the Aspen clients. [Individual #11] stated that he felt threatened by [Individual #25] because he thinks that [Individual #25] might sucker punch him. [Individual #11] was asked what he would do if a client refused to cooperate with him. [Individual #11] became impatient with the questions at this time and refused to answer any further questions." The investigation included the results from seven staff interviews and observations. The investigation stated when staff were asked what individuals they needed to watch most closely and	{W 127}		

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{W 127}	Continued From page 30 why, five out of the seven staff responded that Individual #11 needed the most supervision. The investigation stated staff were asked what areas on the unit were difficult to monitor. The investigation stated the areas of concern included bedrooms, the back yard, the television room, the laundry room and classrooms when they were left unlocked. The investigation stated "During personal observations conducted by the investigators, several concerns were noted. The staff desk seemed to separate staff and clients and became an obstacle that clients and staff gravitated to and obscured the vision on the area. Staff often became engaged at the desk and did not interact with clients as much when they were at the desk. Two doors leading out to the back yard are separated by a kitchen area and living area. Clients were able to exit these doors without staff keeping track of how many clients were outside together. The TV room has glass half way to the floor but stops at waist level. Staff was not able to see clients sitting down efficiently from outside of the TV room. The TV room is sometimes dark in the evenings when clients are watching TV or movies and this impedes staff view of clients. Staff was often separated by individuals needing attention and remaining clients were not constantly monitored. This usually happened for only brief moments but there was one observation made where one staff was a medication passer in the nurses station, one staff was in the kitchen assisting clients with breakfast, one staff was assisting a client in their room and one staff was at the desk on the phone getting work information for another client. This left only the remaining staff that was assigned as a 1-1 on the floor monitoring activities."	{W 127}		

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{W 127}	Continued From page 31 The conclusion of the investigation stated "This investigator found that although no staff was directly found at fault for neglect, there were several areas that contributed to the possibility of sexual misconduct to occurring [sic]." The investigation included the following recommendations: "1. Staff work desk on the units could be converted to client area. This would prevent staff from gravitating to one area in the unit and help facilitate better client interactions and supervision. 2. Staffing assignment could be reassessed to insure coverage of all areas that were identified as concerns. Staff could be assigned to designated area such as Kitchen, Day Hall or Alternate class room. It may be more efficient to assign a staff that is responsible for doing 10-15 minute checks on all clients assigned to the specific unit as well as area checks with documentation to show that checks were completed. This could be also scheduled during times of chaos, client behaviors and shift change. 3. Additional training on risk factors and specific supervision duties and techniques could be provided as an on-going staff improvement initiative. 4. TV rooms could be required to have staff supervision when in use or directional mirrors could be placed in the room so that staff could view clients from outside the area. 5. Pay periods and scheduled outings could be staggered or alternated to prevent planning of inappropriate events during these times. 6. During chaotic times of client behaviors, one staff could be designated to do visual checks on identified clients with safety risks. 7. Activities could be reassessed so that several do not occur at the same time. Medication pass	{W 127}		

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{W 127}	Continued From page 32 could be done after breakfast. This could be most difficult to address due to client personal centered schedules." However, the investigation included an Administrative Review, dated 2/20/09, which stated "Because of the lack of dates and times, it was not possible to determine whether staff negligence was an issue...[Individual #12] was moved to the other side of Aspen during the investigation and he has indicated the desire to remain there so that move will be permanent. On the date the allegation was received I asked [QMRP's name] to retrain staff in appropriate supervision (i.e., rounding through the areas at least every 15 minutes if clients were engaged in independent activities), also alerted her to the two areas that appear to be higher risk areas." No documentation as to why the Investigative Team's recommendations were not implemented was included in the report. The Administrator was interviewed on 3/6/09 from 9:18 - 10:34 a.m. When asked about the 1/25/09 BRF between Individual #11 and Individual #12, the Administrator stated if the QMRP had recognized it, taken action, and conducted an investigation, it would not have risen to the level of a staff neglect investigation. When asked what corrective action was taken to protect Individual #12 as well as other potential victims, the Administrator stated she asked the QMRP to have one staff make rounds during times of distraction and chaos every 15 minutes to check individuals' whereabouts. When asked about the changes since the 1/25/09 incident, the Administrator stated she believed staff were trained to be more vigilant during times of chaos,	{W 127}		

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{W 127}	Continued From page 33 and staff were expected to know where each individual was at 15 minutes intervals, although staff did not actually have to see each individual. When asked how supervision had changed since 1/25/09 incident, she stated she could not answer as it was the team and the QMRP's responsibility to come up with the plan for corrective action. Confidential interviews were conducted with seven (7) direct care staff assigned to the Aspen Unit throughout the day and evening on 3/5/09. When asked about the level of supervision, all staff stated the fifteen minute checks had been in place for no less than 6 months. When asked how the checks were completed, two of the seven staff reported if individuals were in their bedrooms and the doors were closed, staff would knock and get verbal confirmation that the individual was indeed in their room. Five of the seven staff stated it was necessary to actually see the individual to ensure the individual was alone and safe. However, the facility's Enhanced Supervision policy, effective 4/22/08, stated "Unless otherwise specified, the expectation for general supervision for individuals who reside as [sic] the [the facility] is as follows: the staff in the area must know where the person is at all times and visually observe the person ever fifteen (15) minutes unless the individual is engaged in independent activities in his/her bedroom or has independent travel as reflected in the Person Centered Plan." No further definition of 15 minute checks or how they were to be completed was provided in the policy. Staff interviews regarding how the 15 minute checks were being implemented were not	{W 127}		

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{W 127}	Continued From page 34 consistent with the Enhanced Supervision policy, requiring individuals to be "visually observed." Without visually observing individuals, who were in close proximity of one another, it would not be possible for the staff to ensure sexually inappropriate behavior was not occurring. Confidential interviews were conducted with seven (7) direct care staff assigned to the Aspen unit throughout the day and evening on 3/5/09. When asked about blind spots in and around the unit, six of the seven staff reported there were several areas of concern including the television room, the laundry room, the kitchen, the calming room, the back yard, the corner of the patio, and flower bed area. One staff stated the flower bed area was the only blind spot he knew of. When asked about the television room, three of the seven staff reported that when 2 or more individuals were in the television room, staff were to be in the room with them. Three staff stated the door needed to be open when 2 or more individuals were in the television room. One staff stated the television room was not a blind spot and he just turned the light on. When asked, all seven staff stated if only 1 or 2 individuals were outside, staff were required to keep them in visual sight. If 3 or more individuals were outside, staff were required to be outside with them. The facility's corrective action related to the 2/5/09 investigation was not sufficient. The plan of correction was to retrain staff on 15 minute checks. Those 15 minute checks had been in place for no less than 6 months and, as evidenced by on-going incidents, were not sufficient to protect individuals from sexual assaults or misconduct. Additionally, how the 15 minute checks were to be conducted was not	{W 127}		

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{W 127}	Continued From page 35 defined (i.e. visualize part of the individual's person, visualize the entire individual's person, receive verbal confirmation of where the individual was, etc.) and staff were not consistent in how they were implementing the 15 minute checks. Further, Individual #11's Psychosocial Risk Assessment, dated 3/3/09, stated "At present, [Individual #11] poses too high a risk to realistically enter a community placement even with 24/7 supervision. [Individual #11] would need a team of male staff to control his angry outbursts, prevent him from going AWOL and harming members of the community. It appears as though either [the facility] or a jail/prison setting is needed to keep [Individual #11] from assaults... [Individual #11] should not be around females of any age alone, whether they be staff, clients or peers in the community. [Individual #11] should always be supervised around minors, male or female, and vulnerable adults due to his history of assaults and impulsivity. [Individual #11] should always be escorted by male staff on the [facility] campus. [Individual #11] should not be allowed to sexually proposition or harass females in person or on the telephone...Legal charges should be pressed if [Individual #11] attempts or commits any crimes of a sexual or violent nature." When asked about increased supervision, the Sex Offender Coordinator (SOC) stated during an interview on 3/4/09 from 1:15 - 2:45 p.m., Individual #11 required 1:1 staffing due to his propensity for violence and high risk to re-offend. The SOC stated Individual #11's workplace also had the potential to create huge problems as Individual #11 worked with female individuals and female staff. However, at the time of the survey,	{W 127}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 127}	Continued From page 36 Individual #11 was under "general supervision" as defined by the facility's 4/22/08 Enhanced Supervision policy. In summary, Individual #12 reported he was being sexually assaulted by Individual #11 on 1/25/09. Staff failed to immediately report the incident to the Administrator and Adult Protection, Law Enforcement, and Individual #12's legal guardian was not notified. Further, not all members of the IDT (QMRP and SOC) were made aware of the allegations in a timely manner and no action was taken to protect Individual #12 and others from Individual #11's ongoing abuse and exploitation. Based on the results of the 2/3/09 polygraph, an investigation was initiated. There was a 2 day delay in reporting the polygraph allegations to the Administrator, Law Enforcement and Adult Protection and a 6 day delay in reporting the polygraph allegations to Individual #12's legal guardian. Further, the investigation was not completed within 5 working days, and the 2/18/09 conclusion was not reviewed by the Administrator until 2/20/09. The conclusion of the investigation included no less that 7 recommendations, including environmental modifications, increased supervision, staff deployment changes, additional training for staff, and a reassessment of the Aspen Unit's activities. None of those recommendations were implemented. Further, there was no documentation as to why the recommendations were not implemented. Instead staff were retrained on the 15 minutes checks and instructed to be more vigilant. However, the 15 minutes checks had been in place at the time of the incidents and staff were not consistent in their understanding of how the	{W 127}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	R 03/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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{W 127}	Continued From page 37 15 minute checks were to be conducted at the time of the survey. The facility's corrective action was not sufficient to ensure Individual #12 and others identified as potential victims (per SOC Individuals #1, #2, #13, #14, and #15) would be protected from Individual #11's exploitation, sexual and psychological abuse, which placed the individuals in immediate jeopardy. b. A BRF, dated 2/16/09, stated Individual #14 was involved in an incident of Sexual Misconduct Level 1. The BRF documented he exposed himself to Individual #11 on two occasions. The BRF showed the QMRP modified the form on 2/18/09 and changed the behavior from Sexual Misconduct to Sexual Assault Level 1. However, no documentation of Administrator notification was present. When asked, the QMRP stated during an interview on 3/5/09 at 4:25 p.m., the behavior was changed as it did not meet the definition of Sexual Misconduct. The QMRP stated she did not investigate the incident further as that was the responsibility of the Lead Investigator. The Administrator was interviewed on 3/6/09 from 9:18 - 10:34 a.m. When asked about the 2/16/09 BRF, she stated it should have been investigated on the Team Review and Action Plan for Significant Events form but "staff were not following procedure." In summary, staff completed a BRF on 2/16/09 documenting Individual #14 engaged in Sexual Misconduct Level 1. The QMRP reviewed the documentation on 2/18/09 and determined the incident met the definition of Sexual Assault, not	{W 127}		

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{W 127}	Continued From page 38 Sexual Misconduct. The QMRP modified the documentation, but took no further action and the form was sent to data entry. The incident was not immediately reported to the Administrator and other officials in accordance with state law, an investigation was not conducted, and appropriate corrective action was not taken in response to the incident. The facility's Client Behavior and Incident Reporting policy was not implemented. The facility's systems were not sufficient to protect the individuals residing at the facility. The policy was not sufficiently developed, implemented and monitored and staff were not adequately trained to ensure all allegations were identified, reported, investigated and appropriate corrective action was taken to prevent re-occurrence. These systematic failures of the facility allowed for the potential for all individuals residing at the facility to be subjected to abuse, neglect, and mistreatment. Note: The facility submitted a Credible Allegation of Compliance on 3/20/09 and an on-site follow-up survey was completed on 3/23/09, verified that the health and safety of individuals were no longer in jeopardy.	{W 127}		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

Susan Broetje – Administrative Director
IDAHO STATE SCHOOL AND HOSPITAL
Idaho Developmental Resource Center
1660 11TH Avenue North
Nampa, Idaho 83687-5000
PHONE 208-442-2812
Fax 208-467-0965
EMAIL broetjes@dhw.idaho.gov

April 10, 2009

Debbie Ransom, R.N. R.H.I.T.
Bureau Chief
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

RE: Idaho State School and Hospital, Provider #13G001

Dear Ms. Ransom:

Enclosed is the Plan of Correction for the state deficiencies cited in the March 27, 2009 survey.

If you have any questions, please feel free to contact me at 442-2812 ext 700.

Sincerely,

SBroetje

Susan Broetje
Administrative Director

TAG #: MM380

Corrective action for examples:

The identified areas needing cleaning have been cleaned and organized.
The shower curtains will be replaced.
The bent window blinds will be replaced.
The toilet bolt covers will be replaced.

Measures or a systemic change to ensure deficient practice does not recur:

Environmental cleaning and repair expectations will be developed, put in written form, and implemented.
All staff will be trained in the expectations.
The expectations will delineate responsible individuals.

Monitoring to ensure deficient practice does not recur:

An environmental review document will be developed for use by the building supervisors. Where relevant, clients will be included in the review processes. The document will include a plan of action for identified concerns and a follow-up to ensure resolution. A copy of the document will be submitted to the applicable QMRP to ensure completion. A copy of this document will be kept by the assigned AA-1 for a period of 12 months.

Date when correction action will be corrected (usually within 60 days):

5/15/2009

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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MM167	16.03.11.075.07 Exercise of Rights Exercise of Rights. Each resident admitted to the facility must be encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end can voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal. This Rule is not met as evidenced by: Refer to W125.	MM167		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the buildings and all equipment were in good repair and kept clean and sanitary for 79 of 79 individuals (Individuals #1 - #79) residing in the facility. The findings include: 1. An environmental review was conducted on the Aspen unit on 3/25/09 from 8:00 - 9:00 a.m., and the following concerns were noted: Individual #17's bedroom and bathroom: - There was a television, stereo speakers,	MM380	RECEIVED APR 13 2009 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE SBroetje TITLE Admin. Director (X6) DATE

Bureau of Facility Standards

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MM380	Continued From page 1 clothes, blankets, a hairnet, a wallet, backpacks, papers, and empty food containers on the floor. - There were food items including Bisquick, pancake syrup, spaghetti noodles, and canned food items stored in the bathroom. There were two waffle irons stored in the bathroom. - There were shoes, drinking cups, dirty clothes, and empty juice bottles on the bathroom floor. Individual #22's bedroom and bathroom: - There were plastic bins overflowing with clothes in the bedroom. There was paper, pieces of drywall, an orange, hangers, a television, and empty soda cans on the floor. - The shower contained no curtain and there was water on the floor in the bathroom. Individual #20's bedroom and bathroom: - There were multiple empty boxes stored in the bedroom. - The shower curtain was hung with 3 hooks and the remaining holes of the shower curtain were torn. There was water on the floor of the bathroom. Individual #21's bedroom and bathroom: - There were soiled linens on the floor of the bathroom. Individual #1's bedroom and bathroom: - There were soiled linens on the floor of the bathroom. Individual #13's bedroom and bathroom: - There were clothes, linens, and two liter bottles of soda on the floor of the bedroom. - The bathroom sink was filled with drinking cups, rolls of toilet paper, and hygiene products. Individual #12's bedroom and bathroom:	MM380		

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MM380	Continued From page 2 - There were clothes and blankets on the bedroom floor. - The shower did not contain a curtain. Individual #23's bedroom and bathroom: - There were DVD players on the floor. Individual #11's bedroom and bathroom: - There were clothes and shoes on the floor. There were additional clothes, a stereo, a tackle box, and a remote control car on one side of the bed and Individual #11 was noted to be sleeping on the opposite side. Individual #2's bedroom and bathroom: - There were clothes, shoes, paper, and empty soda cans on the floor. - There were soiled clothes on the floor of the bathroom. Aspen 1 Kitchen: - The oven contained burned-on food. Aspen 2 Kitchen: - The oven contained burned-on food. - The microwave contained food splatters. 2. An environmental review was conducted on the Pine unit on 3/25/09 from 9:05 - 9:50 a.m., and the following concern was noted: Individual #7's bathroom: - The shower did not contain a curtain. 3. An environmental review was conducted on the Evergreen unit on 3/25/09 from 10:50 - 11:05 a.m., and the following concern was noted: Kitchen: - There was a soiled washcloth under the one of	MM380		

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MM380	Continued From page 3 the four legs of the dining table. 4. An environmental review was conducted on the Spruce unit on 3/25/09 from 11:05 - 11:15 a.m., and the following concern was noted: Individual #78's bedroom: - The window blinds were bent on all four windows. 5. An environmental review was conducted on the Birch unit on 3/25/09 from 1:55 - 3:00 p.m., and the following concerns were noted: Individual #38's bathroom: - There was cassette tapes, books and loose make up on the bathroom counter. Individual #36's bedroom and bathroom: - There were clothes covering the bedroom floor. The desk top was covered with papers and books. - The bathroom counter had loose tobacco on it. Individual #29 bathroom: - There were wet towels and soiled clothes covering the bathroom floor. The Relaxation room: - The recliner had food crumbs on it and by the recliner was a cup with dried food (appeared to be peanut butter) and a spoon in it. The wall had 2 black marks on it. Birch 1 Kitchen: - There was an 8 inch cake pan with burned-on food. - There were food splatters in the microwave. - There were what appeared to be food crumbs in numerous drawers.	MM380		

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MM380	Continued From page 4 Birch 2 Kitchen: - There were food splatters in the microwave oven. - There was burned on grease on cookie sheet and two skillets had burned on food on them. 6. An environmental review was conducted on the Redwood unit on 3/26/09 from 1:37 - 2:00 p.m., and the following concerns were noted: - On unit 173, in the main bathroom, the first toilet closest to the door was missing both toilet bolt covers. - On unit 173, in the main bathroom, the second toilet from the door was missing one toilet bolt cover. - On unit 174, in the main bathroom, the first toilet closest to the door was missing one toilet bolt cover. - On unit 174, the three cushion couch in front of the television contained food debris between and underneath the cushions.	MM380		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

April 2, 2009

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **March 27, 2009**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004031

Allegation #1: Individuals are allowed to hit their head and do not receive appropriate medical treatment after the incidents.

Findings: An unannounced on-site complaint investigation was conducted from 3/24/09 - 3/27/09. During that time, observations, record review, staff interviews were completed with the following results:

Observations were conducted throughout the survey and individuals were not noted to engage in head hitting or other self injurious behaviors.

Ten individuals' records were reviewed. Of those 10 records, 5 individuals' records contained documented evidence that they engaged in self injurious behaviors including biting their hands and arms, hitting their heads, and inserting staples under their skin. The 5 individuals' medical records were reviewed and showed nursing personnel had conducted appropriate assessments and neurological evaluations after the individuals engaged in head hitting or other self abusive behaviors.

Five direct care staff were interviewed during the survey. When asked, all five staff reported they were required to intervene and report all self injurious behavior to the facility's Administrator and nursing personnel.

The facility's Client Behavior and Incident Reporting policy, dated 3/20/09, stated self injurious injuries and inserting items under the skin were to be reported to the Administrator and first aid was to be provided if needed.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals' parents/legal guardians are not being notified of significant events.

Findings: An unannounced on-site complaint investigation was conducted from 3/24/09 - 3/27/09. During that time, observations, record review, and individual and staff interviews were completed with the following results:

Ten individuals' records were reviewed. Eight of the 10 individuals' records documented the individuals had legal guardians. The remaining two (2) individuals did not have guardians. Their records showed their family members were involved in their care.

The two individuals without legal guardians were interviewed during the survey. One individual stated she did not care what was reported to her family members. The second individual stated she requested specific behavioral information not be reported to her family members.

During an interview on 3/24/09 from 2:46 -2:55 p.m., the Social Worker stated family members were to be notified of only those events identified in the individuals' records to ensure their right to privacy was upheld.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Individuals' rooms are filthy (clothes, food wrappers on the floor, rotten milk, etc.).

Findings: An unannounced on-site complaint investigation was conducted from 3/24/09 - 3/27/09.

During the course of the survey, an environmental review of the facility was conducted. Multiple bedrooms and bathrooms were not observed to be kept clean and sanitary.

For example, bedrooms were noted to be disorganized. There were hampers overflowing with dirty/soiled clothes, beds were unmade, and empty soda cans, paper, hangers, etc., were noted to be lying on bedroom floors. Bathroom showers were noted to contain damaged or missing shower curtains and soiled/dirty clothes were noted to be lying on bathroom floors.

Therefore, the allegation was substantiated and deficient practice was identified at the state level at M380.

Conclusion: Substantiated. State deficiencies related to the allegation are cited.

Allegation #4: Individuals' rights to visit their family and attend religious activities are not being upheld.

Findings: An unannounced on-site complaint investigation was conducted from 3/24/09 - 3/27/09. During that time, observations, record review, and staff interviews were completed with the following results:

Observations were conducted throughout the survey. Individuals were noted to leave the facility with staff to go out to dinner and attend community events.

Ten individuals' records were reviewed. No concerns with community integration activities were noted. Individuals' information logs documented their attendance at religious functions and visits from family members and friends. Further, individuals' visitor sign-in logs were reviewed and no concerns were identified.

During an interview on 3/24/09 from 2:46 -2:55 p.m., the Social Worker stated individuals were allowed to attend off campus activities and receive visitors. The Social Worker stated the facility requested a couple of days notice prior to the activity in order to arrange for staffing necessary for the individual's needs.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Suicide precautions are not being followed.

Findings: An unannounced on-site complaint investigation was conducted from 3/24/09 - 3/27/09. During that time, observations, record review, staff interviews, and the facility's Suicide Prevention policy was reviewed with the following results:

The facility's Suicide Prevention policy, dated 8/7/08, stated if an individual threatened suicide, staff were to immediately ensure the individual was safe, provide the individual with one-to-one staff, and request an assessment from a professional trained in suicide assessments.

The policy stated staff were to move the individual to an empty bedroom if one was available. The policy stated if an empty bedroom was not available, staff were to remove all dangerous items from the individual's bedroom. The policy stated the individual was to be re-assessed within 12 - 24 hours of the initial assessment.

Observations were conducted throughout the survey. Three individuals were noted to be one-to-one due to their maladaptive behaviors. One individual was observed to be one-to-one with a male staff in an empty bedroom due to the individual's threats of suicide.

Ten individuals' records were reviewed. Three of the 10 individuals' records documented the individuals periodically threatened suicide. Those three records contained completed suicide assessments and re-assessments, enhanced supervision sheets, and room search forms. No concerns were identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

MATT HAUSER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

April 1, 2009

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **March 27, 2009**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004052

Allegation: Allegations of sexual abuse are not reported to Adult Protection and Law Enforcement and are not investigated.

Findings: An unannounced onsite follow-up survey and complaint investigations were conducted from 3/23/09 to 3/27/09. During that time observations, record review, and staff and individual interviews were conducted with the following results:

Two investigations related to sexual abuse were reviewed. The first investigation stated an individual alleged that a second individual was raped by a female staff person. The investigation stated the second individual was interviewed and reported he was off-campus with a one-to-one male staff when the alleged rape occurred. The investigation stated the second individual reported he was not raped.

The second investigation showed the same individual who made allegations in the first investigation also alleged he was raped by a Qualified Mental Retardation Professional on 3/22/09. The investigation stated the individual informed his staff person and called Adult Protection at 3:42 p.m. that day and reported the incident.

The investigation also showed that within two hours of the allegation, the individual was interviewed by his group counselor and the individual recanted the allegation. Therefore, law enforcement was not notified.

Further, the Administrator-on-Duty (AOD) report for 3/22/09 at 3:42 p.m. showed the individual was one-to-one with a male staff due to making threats of suicide. He left the yard with staff following him and had given a note to his staff that he was going to run away that night. When the individual and his staff returned to the unit, he called Adult Protection and alleged he was raped by the QMRP (who was the AOD at the time). The AOD was notified by the individual's one-to-one staff of the allegation. The AOD called the Administrator and was told to stay off the unit. The individual's group counselor interviewed the individual within two hours of the allegation and the individual recanted the allegation. The AOD report stated the campus nurse also conducted an assessment on 3/22/09 after the allegation was made and there was no documentation or evidence of rape.

An interview was conducted with the individual and group counselor on 3/26/09 at 11:00 a.m. When asked about the allegations, the individual stated there were no rapes. He stated he had a bad weekend and was mad at staff.

Conclusion: Unsubstantiated. Allegation did not occur.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MATT HAUSER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw